STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165411	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southfield Wellness Community	2416 Des Moines Street Webster City, IA 50595

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility investigation, dignity policy/procedure review, resident and staff interviews, the facility failed to provide personal care to a resident incontinent of stool in a timely manner that promoted their dignity and quality of life for 1 out of 4 residents reviewed. (Resident #1). The facility identified a census of 56 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #1 could understand and other understood them with no behavior or mood issues. Resident #1 required dependent assistance with toileting hygiene and frequently incontinent of bowel. The MDS included diagnoses of hypertension (high blood pressure), neurogenic bladder (condition where nerve damage disrupts the brain-bladder communication, causing problems with storing and releasing urine), non-Alzheimer's dementia, and depression.The Care Plan with a target date of 1/17/26, indicated Resident #1 required assistance of 2 staff for pivot transfers and use of front wheeled walker for toileting.Resident #1's Documentation Survey Report dated 11/30/25, documented large amounts of diarrhea at these times: 4:28 PM, 5:15 PM, 5:50 PM, 6:40 PM and 7:20 PM.The Final Investigation Summary for Incident Report dated 11/30/25, documented, on 11/30/25 Staff A, Licensed Practical Nurse (LPN) with the Director of Nursing (DON) on the phone went to Resident #1's room to interview them about an incident Staff C, Certified Nursing Assistant (CNA), reported. Staff A asked Resident #1 if anyone said anything mean that evening. Resident #1 stated they couldn't recall. Staff A asked if an aide came and told him he would have to wait to be changed. Resident replied yes, they said I'd have to wait in my poopy diaper. Resident #1 couldn't recall who made the comment. Staff C reported she assisted Resident #1 with cares before leaving to go on break at approximately 6:00 PM. Staff C reported when she came back from break at approximately 6:30 PM, Staff D, CNA, told them, they let Resident #1 know he would have to wait until Staff C got back from break to get assistance which would be in a few minutes. Resident #1 told Staff D, he had a bowel movement when they answered the call light at approximately 6:25 PM. Staff C reported when she went to Resident #1's room and did incontinence cares on him, Resident #1 told her the other aide said he had to wait until she got off break. The DON followed up with Staff D, via phone call as they left the building after their shift ended. Staff D confirmed to the DON she let Staff C know when they returned from break Resident #1 called and needed help with incontinence cares. At the time of reporting to Staff C, Staff D helped another resident and told Staff C if she couldn't find another staff on shift to help her, Staff D would help her with Resident #1 when Staff D finished with the resident she currently was with. Staff D reported to the DON she responded to Resident #1's original call light and when she entered the room, Resident #1 told Staff D he had a bowel movement. Staff D reported she told Resident #1 she would go and find another staff to help her as Resident #1 required assistance from 2 staff for incontinent cares. Staff D had every intention to go back and help Resident #1. Staff D reported to the DON while trying to find another CNA to help her with Resident #1's incontinent cares, Staff D found another resident needing immediate assistance and had to assist them due to safety concerns. Staff D adamantly denied telling Resident #1 to wait in a poopy diaper.On 12/16/25 at 1:00 PM, Staff D stated on 11/30/25, Resident #1 put on his call light sometime after supper. When Staff D went to answer the call light, Resident #1 stated he soiled his brief again, due to diarrhea and he needed changed. Staff D told Resident #1 she needed to find another staff member to assist cleaning Resident #1 up and left the room. Staff D, said Resident #1 put on the call light again and Staff D went back into the room and explained she couldn't find another staff member to assist her clean Resident #1 and asked if it was ok to wait 15 minutes or so until Staff C, got done with break and then they would come and change him. Staff D, proceeded to go down another hallway and noticed another resident needing immediate assistance and forgot to tell Staff C Resident #1 needed changed. Staff D said when she remembered Resident #1 needed changed, Staff C and another staff member already completed the task. Staff D adamantly denied telling Resident #1 to sit in a poopy diaper. Staff D acknowledged it is Resident #1's right to have their brief changed as soon as possible, and Resident #1 has the right to have respect and dignity from all staff. On 12/16/25 at 1:45 PM, Resident #1 stated after supper on the evening of the incident, not sure of the date, he put on his call light due to soiling his brief due to having diarrhea. Staff D, sometime after supper answered the call light, and said they needed to go and find another staff member to assist them with changing Resident #1's soiled brief. Staff D left the room. Resident #1 then put on the call light again. Staff D came back into the room and explained Staff D